Effective 07-01-2014

WEST SUBURBAN HEALTH GROUP
BENCHMARK PLAN COMPARISON CHART July 1, 2014

red font indicates change or clarification	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
	CHOICENET BENCHMARK PLAN	BENCHMARK PLAN	BENCHMARK PLAN	BENCHMARK PLAN
BENEFIT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Lifetime Benefit Maximum	None	None	None	None
Deductible - (Benchmark Plans only) applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - *See plan document for full details*	Individual $250 Family $750	Individual $250 Family $750	Individual $250 Family $750	Individual $250 Family $750
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year. NOTE: Prescription co-pays do not count towards the OOP maximum.	$2,000 Individual $4,000 Family per plan year	$2,000 Individual $4,000 Family per plan year	$2,000 Individual $4,000 Family per plan year	$2,000 Individual $4,000 Family per plan year
Family Covered	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Member must select	Member must select	No selection required	Member must select
Specialist Referrals	PCP must refer	PCP must refer	No referral required	PCP must refer
Providers of Service	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 17,000 providers and 50 hospitals. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT				
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Deductible applies then: Tier 1 & Tier 2 :$300 per/Admit Tier 3 : $700 per/Admit NOTE-Mental Health/Substance Abuse copay $200	Deductible , then $300 / $700 copay	Semi-private room & board & ancillary services Tier 1: $300 copay, then deductible applies Tier 2: $700 copay, then deductible applies. NOTE-Mental Health/Substance Abuse copay $300	$300 copay per admission, then deductible. No co-pay or deductible for Mental Hospital/Substance Abuse Facility
Physician Services	Nothing	Nothing	Nothing	Nothing, after deductible

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Skilled Nursing Facility	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then covered in full	Covered in Full after Deductible, up to 100 days per plan year	$300 copay per admission, then deductible Max of 100 days per year.
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	Nothing	Nothing
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	$100 copay, then deductible applies (Inpatient copay applies if admitted)	$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)
Emergency Care in Doctor's Office	n/a	n/a	n/a	n/a
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible applies, then $150 copay per visit	Deductible, then $150 copay	$150 copay per outpatient surgery, then deductible	$150 copay per outpatient surgery, then deductible
CT, MRI and Pet Scans	Deductible applies, then $100 Copay per procedure	Deductible, then $100 copay (scheduled outpatient)	Deductible, then $100 copay	$100 copay, then deducutible
	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient Services	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Physical Therapy	Copay: $20 per visit - Limited to 30 visits per PlanYear	$20 copay; up to 60 visits per calendar year	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	$20 copay. PT / OT Max limit up to 60 visits per calendar year
Office Visits Primary Care Physician	$20 copay per visit	$20 copay	$20 copay per visit	$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$20 copay per visit	$20 per visit	$20 copay per visit	$20 copay per visit
Office Visits Specialist	Tier 1 - $25 copay per visit Tier 2 - $35 copay per visit Tier 3 - $45 copay per visit	$35 copay per visit	$35 copay per visit	$35 copay per visit
OB/GYN	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Routine Vision Exam	$20 copay per visit; one exam every 2 plan years. $0 copay for children under 5 years of age	$0 copay; one visit every 12 months	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers
Pre-Admission Testing -	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full

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Maternity Care visits	Nothing	Nothing	Nothing for prenatal and postnatal outpatient care	Prenatal: $20 copay first visit only; Post: $20 copay per visit after deductible
Dental Services	Preventative dental for children up to age 13 - Tier 1 Copayment per visit up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	**Children under age 12**: Preventive dental up to two exams per cal. yr., incl. Cleaning, fluoride treatment and x-rays. **All members**: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed.	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT	**Family dental coverage:** $10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
OTHER FEATURES				
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
Home Health Care	Member cost sharing depends on types of services provided and tier placement of provider rendering dervices, as listed in the Schedule of Benefits. For example, for services provided by a physician, see "physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Hospice Care	Same as Home Health Care	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Durable Medical Equipment	Deductible, then covered in full	Deductible, then 20% coinsurance Deductible, then 20% coinsurance	Deductible, then covered in full	Deductible, then covered in full 20% coinsurance after the deductlbe for prosthetic limbs which replace, in whole or in part, an arm or leg.
Ambulance	Nothing when medically necessary	Deductible then covered in full	Deductible then covered in full	Deductible then covered in full
Radiation Therapy	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Chemotherapy	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full	Deductible, then covered in full
Chiropractor Visits	$20 copay per visit, 20 visits per plan year	$20 copay per visit. 12 visits maximum per calendar year	$20 copay per visit; up to 12 visits per calendar year	$20 copay per visit; up to 12 visits per calendar year.

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Prescription Drugs (Inpatient drugs paid in full) Co-pays do not count towards OOP Maximum	**Retail Pharmacy:** Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay	**Retail Pharmacy:** Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay	**Retail Pharmacy:** Tier 1: $15.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $30.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay	**Retail Pharmacy:** Tier 1: $10.00 copay Tier 2: $25.00 copay Tier 3: $50.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $20.00 copay Tier 2: $50.00 copay Tier 3: $110.00 copay
Fitness Benefit	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**
	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Up to **$300** reimbursement toward membership or exercise classes at a health club. See plan materials for details. Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details. JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROG -25% OFF A PREMIUM/METABOLIC PROG. NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROG	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for indiv contracts)and Direct Care members up to **$500** per family contract (**$250** for indiv contracts) to use toward health club memberships, Pilates, Yoga classes, Weight Watchers® prog, and local, school sports prog and now fitness related equipment. The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See

* **Fallon DirectCare** - Members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group, Fallon Clinic, Highland Healthcare Associates IPA, Lahey Clinic, Lawrence General IPA, Lowell General PHO, Mount Auburn Cambridge IPA, and Northeast PHO.

****FCHP SelectCare** - Members have access to FCHP Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern, Massachusetts.